| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 NAME OF PROVIDER OR SUPPLIER | | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE (X3) DATE SUR COMPLETE 09/27/2011 | | | TED | |
|---|--|--|--------|-------------------------------|--------------------------------|----------------------|
| | PROVIDER OR SUPPLIE ALK VILLAGE AT I | | 1302 N | LESLEY AVE APOLIS, IN46219 | | |
| | SUMMARY (EACH DEFICIE REGULATORY O This visit was for Complaints INO IN00096460. Complaint Num IN00096270 - Strederal/State defallegation is cite IN00096460 - Strederal/State defallegation is cite Unrelated deficit | NDIANAPOLIS STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) or investigation of 10096270 and abers: substantiated. efficiency related to the ed at F309. substantiated. efficiency related to the ed at F157. dencies cited. deptember 22, 23, and 27, r: 000222 er: 155329 | | | f this forth , or of ests n be | (X5) COMPLETION DATE |
| | Survey Team: Mary Jane G. F Census Bed Typ SNF: 24 SNF/NF: 140 Total: 154 Census Payor T Medicare: 33 | oe: | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NOTU11 Facility ID:

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 09/27/2011 | |
|--|--|--|---------------------|--|----------------------|
| NAME OF F | PROVIDER OR SUPPLIEF | · 3 | | ADDRESS, CITY, STATE, ZIP CODE | |
| ROSEWA | ALK VILLAGE AT IN | NDIANAPOLIS | | LESLEY AVE IAPOLIS, IN46219 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| TAG | Medicaid: 95 Other: 26 Total: 154 Sample: 6 These deficienci findings cited in 16.2. | es also reflect state accordance with 410 IAC | TAG | DEFICIENCY) | DATE |

| | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU: A. BUILI | | NSTRUCTION 00 | (X3) DATE S COMPL | ETED |
|--------------------------|---|---|----------------------|---------------------|---|------------------------|----------------------------|
| | | 155329 | B. WING | | | 09/27/2 | UT1 |
| | ROVIDER OR SUPPLIER | | | 1302 N L | DDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN46219 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| F0157 SS=D | A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial status conditions or clinical alter treatment significant change mental, or psychosocial status conditions or clinical alter treatment significant change of the psychosocial status conditions or clinical alter treatment significant change in condition and it is a change in resident and, if known and it is a change in resident and it is a change in resident and it is a change in resident state law or regular paragraph (b)(1) of the facility must resident's legal regramily member. Based on record to immediately in physician when the condition, in that displayed signs a status changes withe nursing staff | nediately inform the with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening cal complications); a need to nifficantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the drin §483.12(a). Ilso promptly notify the own, the resident's legal interested family member range in room or roommate excified in §483.15(e)(2); or ent rights under Federal or actions as specified in of this section. Decord and periodically and phone number of the oresentative or interested inform a resident's here was a change in | F01 | | F157 Notify of changes (injury/decline/room) It is the practice of this provider ensure that all alleged violations involving notify of changes (injury/decline/room) are provide accordance with State and Fede law through established procedu. What corrective action(s) will be | ed in eral ures. | 10/19/2011 |
| FORM CMS-2: | 567(02-99) Previous Version | ons Obsolete Event ID: | I0TU11 | Facility II | D: 000222 If continuation sh | neet Pac | ge 3 of 29 |

Page 3 of 29

| NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN46219 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE | MPLETED | 00 COMPI | MULTIPLE CO UILDING | STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | |
|--|---------|---|---------------------|--|---|-----------|
| NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1302 N LESLEY AVE INDIANAPOLIS, IN46219 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE | 7/2011 | | | 155329 | | |
| ROSEWALK VILLAGE AT INDIANAPOLIS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) INDIANAPOLIS, IN46219 (X5) PREFIX (EACH OF RECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | PROVIDER OR SUPPLIER | NAME OF I |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE | | | | IDIANAPOLIS | ALK VILLAGE AT IN | ROSEWA |
| PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY COMPLETION DATE | (115) | - THE OLIO, 114-02-15 | | | | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE | | | | | | |
| taken for those residents found to | | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | ` | |
| I INTERVENTION FOR 4 NOURS. | | taken for those residents found to | | 4 hours. | intervention for 4 | |
| This deficient practice affected of 1 of 3 | | | | actice affected of 1 of 3 | This deficient pra | |
| residents sampled for physician practice? | | practice? | | d for physician | residents sample | |
| notification in a sample of 6. [Resident The resident no longer resides in the | | _ | | | | |
| "A"] facility. | | facility. | | | | |
| How will you identify other | | How will you identify other | | | | |
| Findings include: residents having the potential to | | | | Findings include: | | |
| be affected by the same deficient practice and what | | | | | | |
| 1. The record for Resident "A" was corrective action will be taken? | | • | | 1. The record for Resident "A" was | | |
| reviewed on 09-22-11 at 12:45 p.m. All residents have the potential to be | | All residents have the notential to be | | - | Diagnoses included but were not limited | |
| Diagnoses included but were not limited affected by this alleged deficient | | | | | | |
| | | practice. | | to metabolic encephalopathy, | | |
| | | | | | hypertension, congestive heart failure, | |
| atrial fibrillation, chronic back pain and All licensed nursing personnel will be | | | | • | | |
| diabetes. These diagnoses remained re-educated on resident change of condition and physician notification | | | | | | |
| current at the time of the record review. current at the time of the record review. procedures by the SDC by 10/18/11 | | | | ne of the record review. | current at the tim | |
| The resident had physician orders dated What measures will be put into | | What measures will be nut into | | | | |
| nlace or what systemic changes | | | | | | |
| 08-08-11 for a Fentanyl [pain medication] will you make to ensure that the | | - | | | | |
| 25 mcg/hr - apply 1 patch topically every deficient practice does not recur? | | deficient practice does not recur? | | | | |
| 72 hours, in addition to morphine sulfate [pain medication] 30 mg ER tablet 1 by All licensed nursing personnel will be re-educated on resident change of | | | | • | · · | |
| [pain medication] 30 mg ER tablet 1 by re-educated on resident change of condition and physician notification | | | | | | |
| Hydroco/Acetaminophen [pain procedures by the SDC by 10/18/11 | | | | | | |
| | | The members of the pure manager | | 1 4 | 1 - | |
| medication] 5 - 325 I tablet by mouth every 4 hours as needed for moderate The members of the nurse manager team will audit the facility 24 hour | | | | - | _ | |
| pain. reports daily Monday thru Friday. | | reports daily Monday thru Friday. | | needed for injouerate | 1 - | |
| | | | | | F | |
| A review of the September 2011, How the corrective action(s) will | | | | A review of the September 2011 | | |
| medication administration record be monitored to ensure the deficient practice will not recur, | | | | | | |
| indicated the resident received all three i.e. what quality assurance | | | | | | |
| medications on the morning of 09-02-11. program will be put into place? | | | | he morning of 09-02-11. | medications on the | |
| The change of condition CQI audit | | The change of condition COI audit | | - | | |
| The nurses notes indicated the following: tool will be completed once weekly | | | | indicated the following: | The nurses notes | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE SU COMPLE 09/27/20 | TED | |
|--|---|---|--------|---------------|---|----------|--------------------|
| | | 155529 | B. WIN | | | 09/21/20 | 11 |
| NAME OF F | PROVIDER OR SUPPLIER | L | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| POSEW/ | ALK VILLAGE AT IN | IDIANAPOLIS | | | LESLEY AVE APOLIS, IN46219 | | |
| | | | | <u> </u> | AI OLIO, IIV 1 0219 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | DATE |
| 1710 | REGUERTORTOR | ESC IDENTIFICATION OF STREET | | 1710 | x4, bi-weekly x2, and then mont | hly | DATE |
| | "00 01 11 10:00 | a.m., A/O [alert and | | | thereafter by the DNS or design | | |
| | | lethargic easy to arouse, | | | The change of condition CQI au | dit | |
| | | e to voice needs et [and] | | | tools will be reviewed monthly by the | | |
| | wants to staff, pl | | | | CQI Committee for six months a | | |
| | [cooperative] with | • | | | which the CQI team will re-evalue the continued need for the audit | | |
| | _ | Resp. [respirations] even | | | | | |
| | - | | | | Deficiency in this practice will re in disciplinary action up to and | sult | |
| | et nonlabor <sic> no cough or shortness of breath."</sic> | | | | including termination of the | | |
| | | | | | responsible employee. | | |
| | "09-02-11 7:00 a | .m. V/S [vital signs] | | | Date of Compliance 10/18/11 | | |
| | 124/74, p [pulse] 98, Biox [arrow pointed | | | | Date of Compilative 10/10/11 | | |
| | downward] 70 si | | | | | | |
| | _ | allway. Head slumped | | | | | |
| | | and dry. Color pale. | | | | | |
| | | | | | | | |
| | | at 2 L [liters] per n/c | | | | | |
| | | Biox. went up to 85 | | | | | |
| | when head was h | 2 2 | | | | | |
| | _ | f but lethargic. Returned ltx. [treatment] done. | | | | | |
| | | low 90's. Will continue | | | | | |
| | to monitor." | low 90 s. Will continue | | | | | |
| | to momitor. | | | | | | |
| | "00 02 11 0.20 ~ | .m. Biox. @ 94 on 2 | | | | | |
| | | <u> </u> | | | | | |
| | | ıla. Responds to staff | | | | | |
| | but immediately | goes to steep. | | | | | |
| | "00 02 11 10:15 | a.m. Res. [Resident] very | | | | | |
| | | om. Helped to bed. v/s | | | | | |
| | | Respirations 20. | | | | | |
| | | to stay awake. Resting in | | | | | |
| | | nt on. Will continue to | | | | | |
| | monitor." | it on. will continue to | | | | | |
| | monitor." | | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MU A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE COMPL 09/27/2 | ETED | |
|--|---|---|-------|---------------------|---|------|----------------------------|
| NAME OF 1 | PROVIDER OR SUPPLIE | ₹ | | | DDRESS, CITY, STATE, ZIP CODE | | |
| ROSEW | ALK VILLAGE AT II | NDIANAPOLIS | | | LESLEY AVE APOLIS, IN46219 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | "09-02-11 11:15 Resident still verespond to quest practitioner] not received to give [intramuscular] apatch 25 mcg ap NP." "09-02-11 11:30 given times 1." "09-02-11 2:30 given times 1." "09-02-11 2:30 given times 1." "09-02-11 2:30 given times 1." "Review of the modated and order [emergency room hospital]." Review of the modated 09-02-11 in the same time a new applied. [Reside hour later. Nurse would respond to pointed downward was applied to the same time and | a.m. v/s 96/56, P 62. ry drowsy et not able to ions. NP [nurse ified. N.O. [new order] Narcan 0.2 mg IM now times 1. Fentanyl plied in a.m. removed by a.m. Narcan IM 0.2 b.m. Speech unclear, Res. a warm and moist." otation with the same date ed the following: b.m. unable to keep head ay open. MD service to send to ER m] at [name of local area arse practitioner note, ndicated the following: s given a pain pill at the a Fentanyl patch was ent] would not wake up 1 e came to get me. She o sternal rub. BP [arrow ard] 50's, given 0.2 Narcan ental status probably too | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE : COMPL | | |
|--|--|--|------------------|----------------|---|---------|--------------------|
| | | 155329 | A. BUI B. WIN | LDING G | | 09/27/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ROSEW | ALK VILLAGE AT IN | IDIANAPOLIS | | | LESLEY AVE APOLIS, IN46219 | | |
| (X4) ID | SUMMARY S | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | Review of the He 09-02-11 indicate Reported to be slareported a decrea consciousness. [hypoxemic." 2. Review of fact at 8:50 a.m., title Condition," and [March 2010], in "POLICY - It is that all changes is be communicated family/responsib appropriate, time intervention occus." "PROCEDURE - Change. a. Any in a resident's commarked change is behavior will be physician with a visit promptly and conscious and constitutions." | Resident] was ility policy on 09-27-11 d "Resident Change of dated as revised 03-10 dicated the following: the policy of this facility n resident condition will d to the physician and le party, and that ely and effective ars." - 2. Acute Medical sudden or serious change indition manifested by a n physical or mental communicated to the request for physician ad/or acute acre licensed nurse in charge hysician." | | TAG | DEFICIENCY) | | DATE |

000222

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2011 FORM APPROVED OMB NO. 0938-0391

| | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329 | A. BUILDING 00 COMPLE | | (X3) DATE SURVEY COMPLETED 09/27/2011 |
|--------------------------|--|--|-----------------------|--|---------------------------------------|
| | ROVIDER OR SUPPLIER | | 1302 N | ADDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN46219 | |
| (X4) ID PREFIX TAG | SUMMARY ST (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| F0225 SS=D | have been found or mistreating resident have had a finding nurse aide registry mistreatment of resident for their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including in and misappropriat reported immediate the facility and to with State law through (including to the Sagency). The facility must halleged violations and must prevent the investigation is the reported to the addrepresentative and accordance with State survey and oworking days of the | nvestigations must be ministrator or his designated to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective | | | |
| | facility failed to the bruising of unknown | review and interview, the thoroughly investigate own origin, for 1 of 3 | F0225 | F225 Investigat/report/allegations/in duals | |
| | residents reviewe | ed for bruising in a | | It is the practice of this provider | to |

000222

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE | | | |
|-----------|---|---|--------|--|--|---|------------|
| ANDILAN | or connection | 155329 | | LDING | | 09/27/20 | |
| | | 100020 | B. WIN | | DDDECC CITY CTATE ZID CODE | 00/21/20 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE LESLEY AVE | | |
| ROSEWA | ALK VILLAGE AT IN | IDIANAPOLIS | | | APOLIS, IN46219 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | reviewed on 09-2 Diagnoses include to aphasia, cereb hypertension, and These diagnoses time of the record Review of the M assessment, date resident required with transfers, be hygiene and toile Review of the nu 07-19-11 at 4:00 following: "CNA [certified of bruises on residussess - noted a h | r Resident "D" was 22-11 at 9:55 a.m. led but were not limited ral vascular accident, d Parkinson's disease. remained current at the d review. inimum data set d 08-12-11 indicated the extensive assistance ed mobility, dressing, eting. | | | ensure that all alleged violations involving investigation/reporting/allegation ividuals are provided in accorda with State and Federal law through established procedures. What corrective action(s) will be taken for those residents found have been affected by the deficience? Resident D's skin was reassess and no skin tears or bruising was identified. How will you identify other residents having the potential to be affected by the same deficience practice and what corrective action will be taken? All residents have the potential to affected by this alleged deficient practice. All licensed nursing personnel were-educated on resident event reporting, investigation and documentation of skin tears, bruising, and injuries by the SDG designee by 10-18-11 The department head team will re-educated on resident event reporting, the investigation and | ns/ind nce ugh ee d to cient ed ss to ent / to be t | |
| | | opth on left hand, and 2 1/2 [centimeters] by 1 | | | documentation of skin tears, bruising, unusual occurrences a | | |
| | _ | depth hematoma." | | | injuries by the DNS/ED or desig by 10-18-11. | nee | |
| | | ed on 09-23-11 at 3:00 | | | | | |
| | | r of Nursing Services | | | What measures will be not into | | |
| | indicated the bru | ising had been | | | What measures will be put into place or what systemic change | | |
| | investigated. | | | | page of mar dysterms sharings | - | |

| AND PLAN OF | F CORRECTION | IDENTIFICATION NUMBER: | | | 00 | COMPLETED |
|-------------|---|------------------------------|-------------|--------|--|-----------------|
| | | | A. BUILDING | | 00 | COMPLETED |
| | | 155329 | B. WIN | | | 09/27/2011 |
| | | | Б. WПV | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF PRO | OVIDER OR SUPPLIER | | | | LESLEY AVE | |
| ROSEWAL | K VILLAGE AT IN | IDIANAPOLIS | | | APOLIS, IN46219 | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | 1 | ID | · | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE |
| | | , | | | will you make to ensure that the | ne |
| | 2 Daniana et da | | | | deficient practice does not red | |
| | | cumentation provided by | | | · | |
| | | ursing Services on | | | All licensed nursing personnel | |
| (| 09-27-11 at 9:00 | a.m., included 35 | | | re-educated resident event rep | |
| ' | "Resident Event Investigation | | | | the investigation and document of skin tears, bruising, and injur | |
| (| Questionnaires." The questionnaire | | | | the SDC or designee by 10-18- | |
| | - | dent's name, room | | | | |
| | | ry, and the date and time | | | The department head team will | be |
| | of event. On the reverse side of the questionnaire was a "sentence" which | | | | re-educated on resident event reporting, the investigation and | |
| | | | | | documentation of skin tears, | |
| | • | | | | bruising, unusual occurrences | |
| | questioned each staff member "Do you know how the areas of bruising occurred to [resident] hands and or have you seen | | | | injuries by the DNS/ED or design | gnee |
| 1 | | | | | by 10-18-11. | |
| t | | | | | At the time of investigation, an | |
| 1 | anything unusual | with [resident] care ?" | | | additional check will be perform | ned |
| | <i>y C</i> | | | | ensuring the investigation is | |
| , | The staff intervie | ws were conducted | | | complete and that the root cause analysis was also completed at | |
| | | | | | time. | i uns |
| | - | or via telephone. The | | | umo. | |
| | • | staff were inclusive to | | | How the corrective action(s) w | /ill |
| | _ | as the staff members did | | | be monitored to ensure the | |
| 1 | not know how th | e injury occurred. | | | deficient practice will not recu | ır, |
| | | | | | i.e. what quality assurance program will be put into place | 2 |
|] 3 | 3. The remainde | r of the investigative | | | p. ogram win be put into place | |
| | questions include | - | | | The resident event audit tool w | ill be |
| ' | Taronono monde | | | | completed once weekly x4, bi-v | • |
| | !!\\/ ar | againmed to some for data | | | x2, and then monthly thereafter facility Unit Manager or designed | |
| | - | assigned to care for this | | | iaciity onit wanagei oi designe | 56 . |
| 1 | resident ?" | | | | The resident event audit tool w | ill be |
| | | | | | reviewed monthly by the CQI | I |
|] ' | "How often do yo | ou care for this resident | | | Committee for six months after | |
| | ?" | | | | the CQI team will re-evaluate the continued need for the audit. | IC |
| | | | | | continued field for the adult. | |
| , | "Did von see anv | one else from the staff | | | Deficiency in this practice will re | esult |
| | "Did you see anyone else from the staff (any department) assisting the resident or | | | | in disciplinary action up to and | |
| | | | | | including termination of the responsible employee. | |
| | | oom. If yes, who and | | | responsible employee. | |
| | when ?" | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MI A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE : COMPL 09/27/2 | ETED | |
|--|---|---|-------|----------------|---|------|--------------------|
| NAME OF F | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | LESLEY AVE APOLIS, IN46219 | | |
| | ALK VILLAGE AT IN | | | <u> </u> | APOLIS, IN40219 | | (115) |
| (X4) ID PREFIX | | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | | DATE |
| | Did anyone from your shift help with the resident? If yes, who." | | | | Date of Compliance 10/18/1 | | |
| | Did you see any visitor or family member in the room during your shift ?" | | | | | | |
| | "Who cared for the resident while you where <sic> on break ?"</sic> | | | | | | |
| | "When you were caring for the resident do you remember the resident bumping or hitting a part of their body? Did anything occur that may have been construed by the resident or witness as intentional, abusive or neglectful?" | | | | | | |
| | "Has the resident recently?" | t been out of the facility | | | | | |
| | "List any informated determine what h | ation, which will help nappened." | | | | | |
| | | y idea of how this of abuse/neglect may | | | | | |
| | "In your own wo | rds, tell me or write | | | | | |
| | _ | c>happened with this | | | | | |
| | resident to the be | est of your knowledge." | | | | | |
| | * | now the cause of the sk the resident what | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155329 | | | (X2) MU: A. BUILI B. WING | DING | NSTRUCTION 00 | (X3) DATE S COMPL 09/27/20 | ETED |
|---|---|--|---------------------------------|---------------------|--|--|----------------------------|
| | PROVIDER OR SUPPLIER | | p. whve | 1302 N I | DDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN46219 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| F0226 SS=D | injury was assess "MD [Medical D date/time." "Family notified, ED/DNS notified ISDH notified data Ombudsman notified APS notified data Ombudsman notified All above question staff member into 3.1-28(d) The facility must d written policies and mistreatment, neg and misappropriat Based on record facility failed to in prevention policy investigate bruisi that when a resid bilateral bruising failed to thorough bruising of unknown | date/time." I date/time." Ite/time." Ite/tim | F02 | 226 | F226 Notify of changes (injury/decline/room) It is the practice of this provider ensure that all alleged violations involving develop/implement abuse/neglect, and abuse of residents and misappropriation resident property are provided i accordance with State and Fedlaw through established proced What corrective action(s) will taken for those residents found have been affected by the definition of the practice? | of n eral ures. De d to | 10/19/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N0TU11

Facility ID:

000222

If continuation sheet

Page 12 of 29

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING (COMPLETE | | | | |
|--------------------------|--|---|--|---------------------|--|---|----------------------------|
| | | 155329 | A. BUII B. WIN | | | 09/27/20 |)11 |
| | PROVIDER OR SUPPLIEF | | • | 1302 N | ADDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN46219 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | .TE | (X5) COMPLETION DATE |
| | 1. The record for reviewed on 09-Diagnoses include to aphasia, cereby hypertension, and These diagnoses time of the record Review of the Massessment, date resident required with transfers, by hygiene and toiled Review of the monotonic Review of t | or Resident "D" was 22-11 at 9:55 a.m. ded but were not limited oral vascular accident, d Parkinson's disease. remained current at the d review. Clinimum data set d 08-12-11 indicated the l extensive assistance ed mobility, dressing, eting. Curses notes, dated p.m. indicated the nurse aide] notified nurse ident hands. Went to be meatoma on 2nd knuckle entimeters and 1 1/2 epth on left hand, and 2 1/2 [centimeters] by 1 depth hematoma." | | | CROSS-REFERENCED TO THE APPROPRIA | to ent to be and C or be and and gnee cur? change C or | |
| | | cumentation provided by Jursing Services on | | | documentation of skin tears, | ni ailu | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | | |
|--|---------------------------------------|---------------------------------------|------------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLET | ED |
| | | 155329 | B. WIN | | | 09/27/201 | 1 |
| | | I . | F | | DDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | LESLEY AVE | | |
| ROSEWA | ALK VILLAGE AT II | NDIANAPOLIS | | | APOLIS, IN46219 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE (| COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | 09-27-11 at 9:00 | a.m., included 35 | | | bruising, unusual occurrences a injuries by the DNS/ED or design | | |
| | "Resident Event | Investigation | | | by 10-18-11. | lilee | |
| | Questionnaires.' | ' The questionnaire | | | • | | |
| | included the resi | ident's name, room | | | At the time of investigation, an | 1 | |
| | | ry, and the date and time | | | additional check will be perform ensuring the investigation is | ea | |
| | | e reverse side of the | | | complete and that the root caus | e | |
| | | as a "sentence" which | | | analysis was also completed at | this | |
| | _ | staff member "Do you | | | time. | | |
| | - | - | | | How the corrective action(s) w | ill | |
| | | reas of bruising occurred | | | be monitored to ensure the | | |
| | | ds and or have you seen | | | deficient practice will not recu | r, | |
| | anything unusua | ll with [resident] care?" | | | i.e. what quality assurance | . | |
| | | | | | program will be put into place? | · | |
| | The staff intervi | ews were conducted | | | Abuse CQI audit tool will be | | |
| | either in person | or via telephone. The | | | completed once weekly x4, bi-w | | |
| | comments by the | e staff were inclusive to | | | x2, and then monthly thereafter | | |
| | the investigation | as the staff members did | | | Abuse CQI audit tools will be | | |
| | | ne injury occurred. | | | reviewed monthly by the CQI | | |
| | | y y y y y y y y y y y y y y y y y y y | | | Committee for six months after | | |
| | 3 The remaind | er of the investigative | | | the CQI team will re-evaluate the continued need for the audit. | e | |
| | questions includ | _ | | | continuou necu for the audit. | | |
| | questions includ | .cu | | | Deficiency in this practice will re | esult | |
| | WXX71 | | | | in disciplinary action up to and | | |
| | 1 | a assigned to care for this | | | including termination of the responsible employee. | | |
| | resident ?" | | | | | | |
| | | | | | Date of Compliance 10/18/1 | 1 | |
| | - | you care for this resident | | | | | |
| | ?" | | | | | | |
| | | | | | | | |
| | "Did you see an | yone else from the staff | | | | | |
| | _ · | assisting the resident or | | | | | |
| | | room. If yes, who and | | | | | |
| | when ?" | · / | | | | | |
| | | | | | | | |
| | Did anyone from | n your shift help with the | | | | | |
| | resident? If yes | _ | | | | | |
| | · · · · · · · · · · · · · · · · · · · | | | | | | |
| FORM CMS-2 | 2567(02-99) Previous Versi | ions Obsolete Event ID: | N0TU11 | Facility I | D: 000222 If continuation s | heet Page | 14 of 29 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE COMPL 09/27/2 | ETED | |
|--|---|--|---------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | S. WINC | STREET A 1302 N I | DDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN46219 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | Did you see any in the room durir | visitor or family member ng your shift ?" | | | | | |
| | "Who cared for t where <sic> on t</sic> | he resident while you oreak ?" | | | | | |
| | you remember th hitting a part of t occur that may h | caring for the resident do ne resident bumping or heir body? Did anything ave been construed by the ss as intentional, abusive | | | | | |
| | "Has the resident recently?" | t been out of the facility | | | | | |
| | "List any information determine what h | ation, which will help nappened." | | | | | |
| | | y idea of how this of abuse/neglect may | | | | | |
| | down exactly <si< td=""><td>ords, tell me or write ic>happened with this est of your knowledge."</td><td></td><td></td><td></td><td></td><td></td></si<> | ords, tell me or write ic>happened with this est of your knowledge." | | | | | |
| | - | now the cause of the sk the resident what | | | | | |
| | | nistered at the time the sed? if so what?" | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N0TU11 Facility ID:

000222

If continuation sheet

Page 15 of 29

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 09/27/2011 | |
|--|---|--|--|---------------------------------------|----------------------|
| NAME OF I | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | |
| ROSEWA | ALK VILLAGE AT IN | IDIANAPOLIS | | I LESLEY AVE NAPOLIS, IN46219 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | staff member int 5. Review of the 09-22-11 at 9:10 Prohibition, Rep Policy and Proce 2010, indicated t "It is the policy of Communities to abuse including pabuse, verbal abuneglect, involunt misappropriation and/or funds." "9. Residents with and competent) a incident, and the writing." "10. An investigassure other residents." | date/time." d date/time." ete/time." e/time." ified date/time." ons were blank for each erviewed. e facility policy on a.m., titled "Abuse orting and Investigation - edure," dated February | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MU A. BUIL B. WING | DING | NSTRUCTION 00 | (X3) DATE COMPL 09/27/2 | ETED | |
|--|--|--|------|---------------------|--|------|----------------------------|
| NAME (| F PROVIDER OR SUPPLIE | R | | | DDRESS, CITY, STATE, ZIP CODE | | |
| ROSE | WALK VILLAGE AT I | NDIANAPOLIS | | | LESLEY AVE APOLIS, IN46219 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENT REGULATORY OF | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | "11. The invest and observation facts and observation facts and observe employees, facts witnessing non-observation from pertinent inform observation by the individual who the made." 6. Review of the 12:00 p.m., title Investigation," a following: "Complete the Four Investigation Questablished policy" "The Charge Numust conduct a pand verbally report Administrator and receive instruction residents from for suspension of in investigation incomplete in the service in | the supervisor or the initial report was e policy on 09-27-11 at d "Resident Event and undated, indicated the desident Event are stionnaire per cy and procedure." arse or department head preliminary investigation fort findings to the and or his designee to ons on protecting the further danger including avolved employees. The cludes the following ch is to be collected upon | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED DOM/27/2011 | | | | ETED | |
|--|---|--|--------------|--|---|----------|--------------------|
| | | 155329 | B. WING | | | 09/27/20 | 011 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE ESLEY AVE | | |
| | ALK VILLAGE AT IN | | | | POLIS, IN46219 | | |
| (X4) ID PREFIX | | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | ID PREFIX | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | * | LSC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | DATE |
| | | ve statement from the in the alleged event. | | | | | |
| | | what happened even if | | | | | |
| | | confused or has a | | | | | |
| | memory deficit | " | | | | | |
| | | ats from the staff who | | | | | |
| | | resident and staff person otain a statement in | | | | | |
| | | ng from the staff person | | | | | |
| | | e alleged event. All | | | | | |
| | statements must l | | | | | | |
| | clarified that it is | | | | | | |
| | | igation. Be certain that tements are clear and | | | | | |
| | | ame's, events, individual | | | | | |
| | • | overall staff demeanor." | | | | | |
| | 3.1-28(a) | | | | | | |
| F0309 SS=D | must provide the n to attain or maintai physical, mental, a | st receive and the facility necessary care and services in the highest practicable and psychosocial well-being, in the comprehensive lan of care. | | | | | |
| | Based on recor | rd review and | F0309 | | F309 Provide care/services | for | 10/19/2011 |
| | • | facility failed to | | | highest well being It is the practice of this provider to en | sure | |
| | identify a diabetic foot ulcer, in that when a resident who had a | · · · · · · · · · · · · · · · · · · · | | | that all alleged violations invo | | |
| | | | | | well being are provided in | ાઇઠા | |
| | _ | abetes, and was | | | accordance with State and Federal law through established procedures. What corrective | | |
| | | e facility with open | | | | | |
| | areas to the lov | wer legs, and was | | action(s) will be taken for those residents found to have been | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N0TU11 Facility ID:

000222

If continuation sheet

Page 18 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155329 09/27/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1302 N LESLEY AVE ROSEWALK VILLAGE AT INDIANAPOLIS INDIANAPOLIS, IN46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE affected by the deficient dependent upon nursing staff for practice? Resident B no longer bathing and dressing, the nursing resides in the facility. How will staff failed to recognize a diabetic you identify other residents having the potential to be foot ulcer and report to the affected by the same deficient physician for interventions. practice and what corrective This deficient practice affected 1 of action will be taken? All residents have the potential to be 3 residents reviewed for diabetic affected by this alleged deficient need/assessment in a sample of 6. practice. All residents with a dx of diabetes had a head to toe [Resident "B"]. assessment completed to identify if any new ulcers were present. All licensed nursing personnel will Findings include: be re-educated on the weekly skin assessments, cna skin assessments during adl care, The record for Resident "B" was identification of and early signs of reviewed on 09-22-11 at 2:50 p.m. wound development by the SDC Diagnoses included but were not or designee by 10-18-11 What measures will be put into place limited to diabetes mellitus, or what systemic changes will hypertension, cerebral vascular you make to ensure that the deficient practice does not accident, and congestive heart recur? All licensed nursing failure. These diagnoses remained personnel will be re-educated on current at the time of the record the weekly skin assessments, cna skin assessments during adl review. care, identification of and early signs of wound development by the SDC or designee by 10-18-11 At the time of admission the 10 random cna skin observations resident was assessed with an will be completed weekly x 4, bi-weekly x2, and then monthly "abrasion to right lateral calf, thereafter by a facility Unit scabbed area to right posterior calf, Manager or designee to ensure skin observations are accurate. discoloration to bilateral lower How the corrective action(s) extremities and scabbed over will be monitored to ensure the scratch to left thigh." The notation deficient practice will not recur,

000222

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | IULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|------------|--|--------------------------------|--------|-------------|---|---------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED | |
| | | 155329 | B. WIN | | | 09/27/2011 | |
| NAME OF 1 | DDOVIDED OD GUDDUUG | D | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| NAME OF | PROVIDER OR SUPPLIE | N. | | 1302 N | LESLEY AVE | | |
| ROSEW | ALK VILLAGE AT II | NDIANAPOLIS | | INDIAN | APOLIS, IN46219 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | | |
| TAG | | R LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | DATE | |
| | of the Interdis | sciplinary Team | | | i.e. what quality assurance program will be put into pl | | |
| | Progress note | , dated 04-19-11 | | | A skin management CQI au | l l | |
| | indicated that | the areas were not | | | tool and will be completed of | | |
| | "open" nor ha | | | | weekly x4, bi-weekly x2, an | d then | |
| | | a aramago. | | | monthly thereafter by a faci | | |
| | | 1 1 . 0 | | | Unit Manager or designee. random cna skin observatio | | |
| | | dmission plan of care, | | | be completed weekly x 4, | | |
| | dated 04-18-1 | 1 indicated the | | | bi-weekly x2, and then mon | thly | |
| | resident had the | he "potential for skin | | | thereafter by a facility Unit | -1.:- | |
| | breakdown re | lated to weakness, and | | | Manager or designee. The smanagement CQIs and cna | | |
| | | bility." Interventions | | | observations will be reviewe | | |
| | | Care included, | | | monthly by the CQI Commit | | |
| | _ | | | | for six months after which the | | |
| | 1 | checks by LN | | | CQI team will re-evaluate the continued need for the audi | | |
| | = | se], CNA [certified | | | Deficiency in this practice w | | |
| | nurse aide] to | do skin check with | | | result in disciplinary action (| up to | |
| | shower and to | notify LN of | | | and including termination of | l l | |
| | | ght multipodus boot." | | | responsible employee. Date Compliance 10/18/11 | e or | |
| | | 5 | | | Ostripilarioc 10/10/11 | | |
| | Review of the | Minimum data set | | | | | |
| | | | | | | | |
| | assessment, d | | | | | | |
| | indicated the | resident was at "risk" | | | | | |
| | for skin probl | ems, but did not have | | | | | |
| | any pressure a | areas at the time of the | | | | | |
| | | n addition the resident | | | | | |
| | | | | | | | |
| | _ | nsive assistance with | | | | | |
| | dressing. | | | | | | |
| | | | | | | | |
| | The resident's | plan of care, dated | | | | | |
| | 05-02-11 indi | cated the resident | | | | | |
| | "requires staff | f assist to complete | | | | | |
| | 1222 | | | | | | |
| FORM CMS-2 | 2567(02-99) Previous Versi | ions Obsolete Event ID: | N0TU11 | Facility 1 | ID: 000222 If continuation | sheet Page 20 of 29 | |

| AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329 | | LDING | NSTRUCTION 00 | COM | TE SURVEY PLETED 7/2011 | |
|---|---|---|---------------------|--|-------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1302 N | DDRESS, CITY, STATE, ZIP (LESLEY AVE APOLIS, IN46219 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | personal hygic to weakness an mobility." | dressing, grooming, ene and toileting due and decreased | | | | |
| | Assessment," | dated 04-18-11 esident's "skin - | | | | |
| | "open areas" ic resident's bilat shower report "refused" the s comment secti "[Resident] re- refused to sho | cated the following: dentified on the teral lower legs. The indicated the resident shower. The | | | | |
| | the "Shower R Review of the notes, dated 0: following: | as unable to provide Leport" for 05-12-11. "Podiatry" progress 5-12-11 indicated the hick painful long | | | | |

| NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS OX-1D SUMMARY STATEMENT OF DEFICIENCIES (DACID DEPICTING MUST HE PRECIPED IN TIPLE TAG ROSEWALK VILLAGE AT INDIANAPOLIS (INDIANAPOLIS, INAGE) toenails, pain left heel. History of present illness: Admits to 2 wk [week] duration of sharp pain left heel with application of sock and shoe. No tx. [treatment] up to this point. Left posterior lateral fluid filled bulla approximately 6 centimeters in diameter, positive for pain with palpitation. Notes/orders: left bulla (wound care nurse) re [regarding] tx. plan. [Nurse] applied bunny boot to relieve pressure and granulex [illegible word]" During an interview on 09-27-11 at 10:45 a.m., the wound care nurse employee #14 indicated the podiatrist told her about the area on the resident's foot. "[resident] had a diabetic ulcer on left heel. It was fluid filled when it started, it was on the bottom, you had to pick up [resident] leg/foot to be able to see it. [Resident] wore prevalon boots when admitted and then we added a pressure relief boot prior to the blister appearing. The heel area of the boot was hollow to help keep | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 09/27/2 | ETED | |
|---|--|-----------------------------------|-------------------------|----------------|--|------|------|
| Total | NAME OF I | PROVIDER OR SUPPLIEF | . | 1 | | | |
| SUMMARY STATEMENT OF DEFICIENCIES PREFIX (REACH DEFICIENCY MUST BE PERCEDED BY FULL TAG toenails, pain left heel. History of present illness: Admits to 2 wk [week] duration of sharp pain left heel with application of sock and shoe. No tx. [treatment] up to this point. Left posterior lateral fluid filled bulla approximately 6 centimeters in diameter, positive for pain with palpitation. Notes/orders: left bulla (wound care nurse) re [regarding] tx. plan. [Nurse] applied bunny boot to relieve pressure and granulex [illegible word] " During an interview on 09-27-11 at 10:45 a.m., the wound care nurse employee #14 indicated the podiatrist told her about the area on the resident's foot. "[resident] had a diabetic ulcer on left heel. It was fluid filled when it started, it was on the bottom, you had to pick up [resident] leg/foot to be able to see it. [Resident] wore prevalon boots when admitted and then we added a pressure relief boot prior to the blister appearing. The heel area of | | | | | | | |
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| it. [Resident] wore prevalon boots when admitted and then we added a pressure relief boot prior to the blister appearing. The heel area of | | on the bottom | , you had to pick up | | | | |
| when admitted and then we added a pressure relief boot prior to the blister appearing. The heel area of | | [resident] leg/ | foot to be able to see | | | | |
| pressure relief boot prior to the blister appearing. The heel area of | | it. [Resident] | wore prevalon boots | | | | |
| blister appearing. The heel area of | | when admitted | d and then we added a | | | | |
| | | pressure relief boot prior to the | | | | | |
| the boot was hollow to help keep | | blister appeari | ng. The heel area of | | | | |
| | | the boot was h | nollow to help keep | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155329 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPI 09/27/2 | LETED | |
|---|--|---|-------|---------------------|--|----------|----------------------------|
| | PROVIDER OR SUPPLIER | | • | 1302 N | DDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN46219 | _ | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) | E | (X5) COMPLETION DATE |
| | podiatrist told started treatment anything about The Weekly slow-21-11, 04-2 lacked identificancerns. How indicated the reconcern, "Left assessment data." The "Wound Stranger Report," dated the "wound was admission, and 05-12-11, with centimeters, we and depth < 0. | ted 05-13-11. Skin Evaluation 05-12-11 indicated as not present on developed on a length of 7.0 idth 6.0 centimeters 1." | | | | | |

000222

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 BUILDING 155329 09/27/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1302 N LESLEY AVE ROSEWALK VILLAGE AT INDIANAPOLIS INDIANAPOLIS, IN46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on the comprehensive assessment of F0322 a resident, the facility must ensure that a SS=D resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on record review and interview, the F0322 F322 Notify of changes 10/19/2011 (injury/decline/room) facility failed to provide the correct gastrostomy tube feeding formula for a It is the practice of this provider to diabetic resident. This deficient practice ensure that all alleged violations involving, NG Treatment/Services affected 1 of 3 residents reviewed for restore eating skills are provided in gastrostomy tube feeding and diabetic accordance with State and Federal law through established procedures. needs in a sample of 6. [Resident "B"]. What corrective action(s) will be Findings include: taken for those residents found to have been affected by the deficient practice? The record for Resident "B" was reviewed on 09-22-11 at 2:50 p.m. Diagnoses Resident B no longer resides within the facility. included but were not limited to diabetes mellitus, hypertension, cerebral vascular How will you identify other residents having the potential to accident, and congestive heart failure. be affected by the same deficient The resident had a gastrostomy feeding practice and what tube due to severe oropharangeal corrective action will be taken? dysphasia. These diagnoses remained All residents with tube feedings have current at the time of the record review. the potential to be affected by this alleged deficient practice. Review of the Interim/Admission Nursing All licensed nurses will be Care Plan, dated 04-18-11 indicated, re-educated on verification of MD orders and the 5 rights of a "Resident requires tube feeding. Potential medication pass in relation to the for complications. Interventions: Tube hanging of g-tube feedings by the feeding diet as order, observe for SDC or designee by 10-18-11 tolerance." Residents with feeding tubes were N0TU11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID:

000222

If continuation sheet

Page 24 of 29

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) | MULTIPLE CON | | (X3) DATE SURVEY | |
|--|--|--------------------------------|--------------|----------------|---|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BI | UILDING | 00 | COMPLETED |
| | | 155329 | B. W | /ING | | 09/27/2011 |
| NAME OF I | PROVIDER OR SUPPLIER |) | | STREET A | DDRESS, CITY, STATE, ZIP CODE | |
| | | | | | LESLEY AVE | |
| ROSEW | ALK VILLAGE AT IN | NDIANAPOLIS | _ | INDIANA | APOLIS, IN46219 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | · | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | | | | | audited to ensure physician orde were followed for the correct | साठ |
| | | ubsequent plan of care, | | | feeding. No concerns noted. | |
| | | ndicated the resident | | | _ | |
| | | eeding to meet nutritional | | | What measures will be put into place or what systemic change | |
| | needs." | | | | will you make to ensure that th | l l |
| | | | | | deficient practice does not reci | |
| | At the time of ad | lmission, the resident had | | | All licensed purses will be | |
| | physician orders | for Diabetes Boost at 80 | | | All licensed nurses will be re-educated on verification of M | o |
| | ml [milliliters] pe | er hour and physician | | | orders and the 5 rights of a | |
| | | hecks 3 times a day. | | | medication pass in relation to th | |
| | | j | | | hanging of g-tube feedings by the SDC or designee by 10-18-11 | ie |
| | The facility chan | ged the tube feeding with | | | | |
| | _ | mula noted as Glucerna | | | Nurses will be required to check | the |
| | 1.2. | 2.2.2.2.2.2.2.110 | | | feeding Q shift to ensure the appropriate feeding is being | |
| | | | | | administered. | |
| | Review of the Di | ietary Progress notes, | | | | |
| | | ndicated "Resident | | | | |
| | | erna 1.2 at 80 ml per hour | | | How the corrective action(s) wi | 4II |
| | | Kcal [kilocalorie's] - prior | | | be monitored to ensure the | |
| | - | was on Boost Glucose at | | | deficient practice will not recur i.e. what quality assurance | , |
| | 80 ml/hr." | was on boost diucose at | | | program will be put into place? | , |
| | ου 1111/11 Γ ." | | | | | |
| | Day is Col | | | | An enteral therapy CQI audit too be completed once weekly x4, | ol will |
| | | irses notes, dated | | | bi-weekly x2, and then monthly | |
| | | m 3:00 p.m. indicated | | | thereafter by a facility Unit Mana | ager |
| | the following: | | | | or designee. | |
| | | | | | The enteral therapy CQI audit to | ol |
| | | duty noted resident had | | | will be reviewed monthly by the | CQI |
| | _ | ld've <sic>[should have]</sic> | | | Committee for six months after the CQI team will re-evaluate the | |
| | | 2, change to glucerna. | | | continued need for the audit. | |
| | | octor] and family notified. | | | | |
| | BS [blood sugar] | [arrow pointed upward] | | | Deficiency in this practice will re in disciplinary action up to and | sult |
| | Received 1x [one time] insulin order." | | | | including termination of the | |
| | | | | | responsible employee. | |
| | Review of the "C | Capillary Blood Glucose | | | | |
| FORM CMS-2 | 2567(02-99) Previous Version | ons Obsolete Event ID: | N0TU1 | 11 Facility II | D: 000222 If continuation sh | neet Page 25 of 29 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | (X2) MU A. BUIL B. WINC | DING | 00 | (X3) DATE (COMPL 09/27/20 | ETED | | |
|--|--|--|--|---------------------|--|-------|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN46219 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE | |
| | "406 mg [millign The record indica 13 additional uni p.m. | dent's blood sugar was ams] / dl [deciliter]." ated the resident received ts of insulin at 12:00 | | | Date of Compliance 10/18/11 | | | |
| | p.m., the Dieticia indicated the diff 1.2 and Glucerna | Perence between Jevity 1.2 was "the amount of the Jevity 1.2 has 52 % | | | | | | |
| | a.m., the Director clarified the form | on 09-27-11 at 11:00 r of Nursing Services nula error was not noted first arrived at 7:00 a.m., | | | | | | |
| F0323 SS=G | environment rema hazards as is poss | nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. | | | | | | |
| | Based on observative record review, the safety of a restriction resident who was upon two staff med mobility, the ensure the aide parts of the safety of the | ation, interview and e facility failed to ensure sident, in that when a s assessed as dependent embers for transfer and nursing staff failed to rotected the resident care, for 1 of 3 residents | F0: | 323 | F323 Free of accident hazards/supervision/devices It is the practice of this provider ensure that all alleged violations involving free of accident/hazards/supervision/des are provided in accordance wi State and Federal law through established procedures. | evice | 10/19/2011 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NOTU11 Facility ID:

D: 000222

If continuation sheet

Page 26 of 29

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329 | | | | ULTIPLE CON LDING IG | 00 | (X3) DATE SURVEY COMPLETED | | | |
|--|---|--|--------|---|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN46219 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | reviewed for injuresulted in the retreatment follow [Resident "C"]. | | | What corrective action(s) will taken for those residents four have been affected by the defipractice? The facility met with resident C hospice provider and educated | d to cient 's them | | | | |
| | The record for Resident "C" was reviewed on 09-22-11 at 11:50 a.m. Diagnoses for the resident included but were not limited to dementia with impulse control, aphasia and psychotic condition. These diagnoses remained current at the time of the record review. Review of the Minimum Data Set assessment, dated 07-07-11 indicated the resident was cognitively impaired, and required extensive assistance with transfer and bed mobility - 2+ staff members, and total assist of 1 staff member with hygiene. | | | | on reporting to the nurses' stati upon their arrival and getting the appropriate information prior to providing care to the residents. Resident C's care plan was alsupdated to ensure the resident provided ADL care in bed with assistance of 2 staff members. How will you identify other residents having the potential be affected by the same deficit | to | | | |
| | | | | | practice and what corrective action will be taken All residents have the potential affected by this alleged deficier practice. All nursing personnel will be re-educated on fall prevention, providing adl care in bed to dependent residents and utilize of cna sheets by the SDC or | to be | | | |
| | indicated the resident indicated the resident of coordination, presented the resident is not voluntarily." | event accident roll out or of able to get out of bed s, dated 09-19-11 at 9:45 | | | A meeting will be held with faci hospice providers educating the the notification of staff of their a getting report, obtaining cna shand requesting facility staff assistance when providing adl to dependant residents on or b 10-18-11 Hospice CNAs will sign in prior providing care to residents, ensithey receive current information regarding their patients. UM to | em on arrival, eets, care efore to suring | | | |
| FORM CMS-2 | 567(02-99) Previous Version | - | N0TU11 | Facility II | D: 000222 If continuation s | sheet Page 27 of 29 | | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155329 09/27/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1302 N LESLEY AVE ROSEWALK VILLAGE AT INDIANAPOLIS INDIANAPOLIS, IN46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE monitor weekly for compliance. "Hospice CNA at resident's bedside providing ADL [activities of daily living] What measures will be put into care. Alerted writer to resident, stating place or what systemic changes resident fell out of bed when rolled to left will you make to ensure that the side for pericare. Writer found resident deficient practice does not recur? lying on stomach on side of bed with All licensed nursing personnel will be copious amounts of blood coming from re-educated on fall prevention, facial area. 911 called r/t [related to] providing adl care in bed to dependent residents and utilization bleeding and multiple lacerations to face of cna sheets by the SDC or and head." designee by 10-18-11 A meeting will be held with facility Review of the Fall Circumstance Report, hospice providers educating them on dated 09-19-11 at 9:45 a.m. indicated "fall the notification of staff of their arrival, getting report, obtaining cna sheets, witnessed - receiving care by the Hospice and requesting facility staff Aide, laying on stomach, no clothes, assistance when providing adl care to dependant residents on or before resident hit head, bruises to bridge of 10-18-11 nose, laceration to bridge of nose, forehead and hairline. Hospice aide states resident was rolled onto left side for How the corrective action(s) will pericare and [resident] rolled out of bed. be monitored to ensure the Sent to ER [emergency room] for eval. deficient practice will not recur, i.e. what quality assurance [evaluation] and tx. [treatment]." program will be put into place? Review of the local area hospital facility A fall management CQI audit tool will be completed once weekly x4, return notation, dated 09-21-11, indicated bi-weekly x2, and then monthly and instructed the nursing staff as follows. thereafter by a facility Unit Manager "Scattered abrasions to or designee. forehead/face/bruises noted to hands. The fall management CQIs will be Bactroban ointment to laceration on face reviewed monthly by the CQI Committee for six months after which after cleaning with peroxide and drying." the CQI team will re-evaluate the continued need for the audit. During an observation on 09-23-11 at Deficiency in this practice will result 9:40 a.m., the resident was observed in

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N0TU11

000222

Facility ID:

If continuation sheet

Page 28 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 09/27/2 | ETED | | | |
|---|--|---|--|---|---|-------------------------------|----------------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN46219 | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | | | |
| | gastrostomy feed resident was obsolerownish/gray/ye forehead, and acresident's nose. When interviewed p.m., the Director indicated the Host notify the nurse of facility staff wou available to assist Interview on 09-Executive Direct Nursing Services scheduled for 09-injury sustained bunder the care of addition this wou facility CQI [Control of the control of the c | 27-11 at 9:30 a.m., the or and Director of indicated a meeting was -28-11 to discuss the by the resident while the Hospice Aide, in ald be a part of the ntinuous Quality ogram and the inclusion | | | in disciplinary action up to and including termination of the responsible employee or restriction for noncompliant hospice staff. Date of Compliance 10/18/1 | | | | | |